EXHIBIT A

213041

THE MIDLAND

Part I - Application For Life Insurance

Please print in dark ink

☐ Check here if application is on multiple lives.
If so, complete a separate application or the appropriate supplement for each proposed insured.

1. Proposed Insured

First Name: KELLY Middle Initial: D Last Name: Couch

Street Address: [redacted]

City: ATLANTA State: GA Zip: [redacted]

Day Phone: 404- 869- 9148

Evening Phone: 404-869-9147

☐ Married ☒ Single

Sex: M Height: 6'0 Weight: 190

Date of Birth: [redacted]/66 Social Security Number (SSN): [redacted]-8600

Place of Birth: KY Drivers License No. / State: [redacted]1741 GA

Citizenship ☒ U.S. ☐ Canada ☐ Other
If other, please complete NB-364.

2. Tobacco Use

a. ☒ Never ☐ Present ☐ Former
b. Type of tobacco use
c. When did you quit using all forms of tobacco?
(month/ year)

3. Occupation

Duties: RESIDENTIAL CLEANING SERVICE
Name of Employer: SELF-EMP
Business Address: SAME

4. Beneficiary

Give full name, address, date of birth, SSN / tax ID number and relationship to proposed insured:
Primary:
ESTATE OF INSURED

Contingent:

5. Owner (if other than proposed insured)

Name

Owner's relationship to proposed insured:
(If trust, give name of trustee and date of trust.)

Street Address

City State Zip Phone

Owner's Social Security or Tax-ID Number

00 3423 0001 92

AUG 31 1998

6. Plan / Riders

Plan Name: ALTIMAT 10 Duration: 10
Face or specified amount: 500,000
If UL: ☐ Option 1 - level ☐ Option 2 - increasing
Planned Periodic Premium
☐ Waiver of Premium (if UL, Waiver of Monthly Deduction)
☐ Guaranteed Exchange Rider (GER)
☐ Accidental Death Amount $
☐ Child Protection Rider (CPR) Amount $
(Complete NB-401)
☐ Other Insured Rider (OIR) Amount $
(Complete separate NB-399)
☐ Other - Plan Amount $

7. Mode of Premium Payment

Send premium notice to:
☒ Proposed insured ☐ Owner ☐ Employer
Select Payment Method: ☐ Single Premium $

	Annual	Semi-Annual	Quarterly	Monthly
Individual Direct Bill	☐	☐	☐	N/A
Pre-Authorized Check	☐	☐	☐	☒

Complete supplement B.

8. List All Insurance in Force on Proposed Insured

a. Company	Business Ins. Yes / No	Amount	ADB	Year Issued
NONE				

b. Is an application for life or health insurance pending with this or any other company or society? ☐ Yes ☒ No
Co. Name Amt.

9. Replacement

Is this insurance intended to replace or change any existing insurance, including annuities, with any company or society?
☐ Yes ☒ No

Co. Name	Policy Number	Amt.

00 3423 10019

10. Name and Address of Personal Physician (if none, so state)

NONE

Date, reason and results for last doctor visit or consultation. _____

11. Annual Income

Earned 85,000 Unearned _____ Net worth 250,000

In the past 7 years, have you filed for bankruptcy? ☐ Yes ☒ No

Bankruptcy type: ☐ Personal ☐ Business ☐ Other Date discharged _____

12. Family History

	Age if Living	Age at Death	State of Health / Cause of Death	Cancer (all types) Yes	Cancer (all types) No	Liver disease Yes	Liver disease No	Heart disease, stroke or circulatory disorder Yes	Heart disease, stroke or circulatory disorder No
Mother	69			☐	☒	☐	☒	☐	☒
Father	67			☐	☒	☐	☒	☐	☒
Siblings				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐
				☐	☐	☐	☐	☐	☐

13. Has any person proposed for insurance:

	YES	NO
a. Any plans to travel or reside outside the USA or Canada longer than a total of two weeks during the next two years? (If yes, complete the Foreign Travel Supplement, NB-364)	☐	☒
b. Been convicted of driving under the influence of drugs or alcohol or had two or more other moving violations, or had a driver's license suspended or revoked in the past 5 years?	☐	☒
c. In the past 5 years, flown or intend to fly as a pilot, student pilot or crew member of any air craft? (If yes, complete the aviation supplement, NB-016).	☐	☒
d. Engaged or plan to engage in any hazardous activity such as any type of racing (e.g. auto, motorboat), any type of flying (e.g. hang gliding, sky diving, ballooning), any type of water sport (e.g. scuba diving), any type of climbing (e.g. mountain, rock, ice), or any other miscellaneous avocation or sport (e.g. cave exploring, rodeo)? If yes, complete appropriate supplemental questionnaire.	☐	☒
e. Been convicted of a felony in the past 10 years?	☐	☒
f. Had any company or society decline to issue, reinstate or renew a policy; offered a rated or modified policy; or postponed or cancelled any insurance on your life?	☐	☒

Details of "Yes" answers. IDENTIFY QUESTION NUMBER, CIRCLE APPLICABLE ITEMS:

14. Questions related to the Interim Insurance Receipt for Proposed Insured

a. In the past 90 days, has the proposed insured been admitted to a hospital or other medical facility, been advised to be admitted, contemplated surgery, or had surgery performed or recommended? ☐ Yes ☒ No

b. In the past three years, has the proposed insured been treated by a member of the medical profession for heart trouble, stroke, cancer, drug or alcohol use, tested positive or diagnosed as having AIDS, or had such treatment recommended by a member of the profession? ☐ Yes ☒ No

If either question 14a or 14b is answered "yes" or left blank, an initial premium payment cannot be accepted with this application and any interim insurance receipt issued is void.

15. Home Office Endorsement

(This section not valid in West Virginia)

0043 03 05 04

PART II - Health History

Full name of proposed insured KELLY D. COUCH Date of Birth [redacted]66 S.S.N. [redacted]-8000

	YES	NO
1. Is any person proposed for insurance now under observation, receiving treatment or taking medication prescribed by a member of the medical profession?	☐	☑
2. In the past 10 years, has any person proposed for insurance ever been diagnosed as having, been treated for or ever had:		
a. Chest pain, palpitations, high blood pressure, heart attack, heart murmur or other disorder of the heart or blood vessels?	☐	☑
b. Cancer, tumors, Kaposi sarcoma, disorder of the skin, swelling of the lymph glands, fevers of unknown origin, severe night sweats, lupus or collagen disorder, arthritis or any bone or muscle disease?	☐	☑
c. Dizziness, fainting, seizures, chronic fatigue, stroke, paralysis, tremor, nervous or mental disorder including anxiety, depression or attempted suicide?	☐	☑
d. Shortness of breath, persistent hoarseness or cough, blood spitting, pneumocystis carinii pneumonia, bronchitis, asthma, emphysema, tuberculosis, allergies, or other chronic respiratory system disorder?	☐	☑
e. Diabetes, thyroid or other endocrine disorder, elevated blood sugar, albumin, blood, sugar or pus in the urine, stone or other disease of kidney, bladder, prostate or reproductive organs?	☐	☑
f. Intestinal bleeding, prolonged diarrhea, weight loss, ulcer, colitis, diverticulitis, chronic indigestion or other disorders of stomach, intestine, gallbladder or spleen?	☐	☑
g. Pancreatitis, hepatitis, cirrhosis or disorder of the liver?	☐	☑
h. Anemia, bleeding tendency or other disorder of the blood?	☐	☑
i. Disorder of eyes, ears, nose or throat?	☐	☑
j. Deformity, lameness or amputation?	☐	☑
k. Has any person proposed for insurance been diagnosed or treated for AIDS by a member of the medical profession, or had a positive test result confirming the presence of the AIDS virus (e.g. HIV, HTLV-III)?	☐	☑
l. Females only: are you pregnant? If yes, due date _____	☐	☑
3. Has any person proposed for insurance ever:		
a. Used any illegal, restricted or controlled substance except as prescribed by a physician? (If yes, complete NB-165.)	☐	☑
b. Been counseled or treated for alcohol or controlled substance use? (If yes, complete NB-164 and/or NB-165.)	☐	☑
4. Has any person proposed for insurance within the past 5 years:		
a. Had a checkup, consultation, illness, injury or surgery?	☐	☑
b. Had an EKG, X-ray or other diagnostic tests?	☐	☑
c. Been a patient in a hospital, clinic, sanitarium, or other medical facility?	☐	☑
d. Been advised to have any diagnostic test, hospitalization, or surgery which was not completed or where results are still pending?	☐	☑
e. Had any condition resulting in over 10 consecutive days of time lost from work?	☐	☑
f. Requested or received a pension, benefits or payment because of injury, sickness or disability?	☐	☑

Details of "Yes" answers. IDENTIFY QUESTION NUMBER; CIRCLE APPLICABLE ITEMS: (Include all diagnoses and names and addresses of all attending physicians and medical facilities.)

MEDICAL ORDERED BY APPS 770-962-1195 #10268

0043 4201 0019

Part III - Authorization to Obtain and Disclose Information

Taxpayer ID Certification

Upon penalties of perjury, I(we), the undersigned applicant (proposed insured or owner if different from proposed insured), certify (1) that the number shown below is my correct taxpayer identification number and (2) that I(we) am(are) not subject to backup withholding because either (a) I(we) have not been notified that I(we) am(are) subject to backup withholding as a result of failure to report all interest or dividends, or (b) the Internal Revenue Service has notified me that I(we) am(are) no longer subject to backup withholding.

☑ Social Security Number [redacted]8600 or ☐ Federal Employer ID Number _____

Authorization

I(we), the proposed insured, authorize any licensed physician, medical practitioner, psychotherapist, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., or any other organization, institution or person, that has any records or knowledge of the health, treatment, or other insurance coverage of any proposed insured named on this application, to give such information to The Midland Life Insurance Company (The Midland) or its reinsurers to assess my application. The information that may be disclosed includes records or facts relating to employment, other insurance coverage, past and present physical and mental state of health, drug and/or alcohol use, character, habits, avocations, finances, general reputation, credit or other personal traits. I also authorize any investigation company which is employed by The Midland, or the General Agent or Agency through which the agent signing this application places business with The Midland, to collect and transmit such records and information, excluding information from the MIB, Inc. I further agree that a photographic copy of this authorization will be as valid as the original. This authorization is valid for two years from the date of this application. I understand that I (or my designated representative) am (is) entitled to receive a copy of this authorization.

Agreement

I(we), the undersigned proposed insured and applicant (if different, both) represent to the best of my(our) knowledge and belief, that all statements and answers in all parts of this application are complete, true and correctly recorded and agree that:

1. No agent or medical examiner of the company is authorized to accept risks, modify contracts or to waive any of the company's rights or requirements.
2. No information has been furnished to any agent or medical examiner in response to any question in any part of this application which is not recorded in the answers to such questions.
3. The entire contract will consist of this application, the policy issued in response to it and any application amendments or personal health statements signed by the proposed insured or applicant.
4. **If an initial premium payment has been made, and an interim insurance receipt bearing the same name and date as this application has been received, no insurance will be effective before policy delivery except as provided in the interim insurance receipt.**
5. **If no such initial premium payment has been made at the time of making this application, or if the company approves this application different from that applied for as to plan, amount, age, classification or benefits, no insurance shall take effect until (a) the policy is delivered to and accepted by me and (b) the full first premium is paid and (c) the statements and answers in all parts of this application then remain substantially correct. *All checks should be made payable to The Midland Life Insurance Company.***
6. Except in West Virginia: Changes to this application relating to plan, amount, age, classification or benefits shall be considered ratified only with the owner's written consent, and any other changes to this application made by the company and noted in Part I "Home Office Endorsement," shall be considered ratified by my acceptance of a life insurance policy containing this application showing such changes.

I(we) acknowledge receiving a disclosure statement concerning (1) insurance information practices, (2) an investigative consumer report, (3) disclosure of medical information, and (4) where applicable, fraud warning. If an initial premium payment was made, I(we) acknowledge receiving an interim insurance receipt and reading it in full.

Signed by the applicant at Atlanta (City) Ga (State) this 28 (day) day of Aug (month), 1998 (year)

X Kelley Clement
Applicant's / owner's signature (if other than proposed insured)

X _____
Official capacity (if signed on behalf of a corporation, trust, etc.)

X Kevin Palombo
Agent's signature

X _____
Proposed primary insured's signature

X _____
In Florida: Agent's name printed as it appears on license and Florida license I.D. number.

X _____
In Florida, secondary addressee name and address